(Mr. BOYD addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

HEALTH SAVINGS ACCOUNTS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Mexico (Mr. PEARCE) is recognized for 5 minutes.

Mr. PEARCE. Mr. Speaker, I rise this evening to discuss the inclusion of health savings account in the Medicare legislation. It is one of the most exciting provisions to business owners in my district.

Health savings accounts are going to change the way that our country looks at health care. It is going to change the way that our companies buy health care. Basically a health savings account is simply an IRA. It is a medical IRA. It is a medical IRA where we are allowed to put money in tax free at any age up to $5,500 a year. An employer or the plea can make the contribution.

The nice thing about the health savings account is that it can be taken out at any age if it is used for medical purposes. So unlike other IRAs which have to be deducted or taken out of the savings accounts after you are 62½, health savings accounts can be taken out now at any age. It can be used to pay for premiums, deductibles, co-pays, prescription drugs, medical supplies or any medical treatments.

The value of this is, Mr. Speaker, that we are going to get to about 30 percent more buying power with our dollar because we make tax free contributions into the plan and we can take tax free contributions out if we pay for legitimate medical expenses.

The nice thing also is that it becomes a part of your estate. It travels with you. It is a thing that will go to the next generation if you do not use it. And so it is a way for you to prepare for your medical expenses, but if you do not use the account, then it becomes a way for your children to pay for their medical expenses.

I think that the example of my company is a very good one, Mr. Speaker. We used to have a company with 50 employees. Almost every year we gave bonuses to employees. I would tell you that if we still owned the business, that we would begin to pay those bonuses sometimes 2, 3, 4, and $5,000 a year into the health savings account. That way we could begin to have the employees use tax free money to pay for their premiums in the program, and if they used the medical services to pay for their deductible, so with tax free money.

Now, if I am paying $5,000 a year into an account for every employee, 2 or 3 years down the road, each employee would probably have 10 to $15,000 in their medical savings account, their health savings accounts. At that point, I would begin to shop for $5,000 deductible rather than $500 deductible. The resulting collapse in premiums is something that I will guarantee will be attractive to every single small business owner in America and most large businesses. Each employee is going to want to look at this as a way to begin to prepare for their medical future.

The important aspect of the health savings account is that after we establish these large accounts to be used for medical purposes for our employees, and they know it is a part of their estate, they will begin to look at their medical decisions with regard to the amount of money that is coming out of their health savings account. It is one of the things that we think will depress the demands, the arbitrary demand that sometimes goes along with medical decisions today.

We think that the health savings accounts is one of the most important pieces of legislation passed during the past year. When employers in my district hear about it, they call our office and begin to ask can they buy that now.

□ 2000

Most insurance companies will begin to have plans this year. Most are saying to me that they will have the plans up and running by the mid-year June of 2004. I think that in the future years, as employers and employees alike begin to combine their efforts into the health savings account, we are going to find real changes in the way that medical care is paid for in this country, and that is the beginning point of most of the reforms that are going to make medical insurance available and affordable to all Americans.

Mr. Speaker, I salute this House in passing the prescription drug bill with the Medicare reforms that included the Health Savings Account.

RURAL HEALTH CARE FOR VETERANS

The SPEAKER pro tempore (Mr. GERLACH). Under a previous order of the House, the gentleman from Texas (Mr. STENHOLM) is recognized for 5 minutes.

Mr. STENHOLM. Mr. Speaker, I am proud tonight to stand and take these 5 minutes in support of the Rural Veterans Access to Care Act of 2003 introduced by my good friend the gentleman from Nebraska (Mr. OSBORNE). I am just happy to say I am glad to be in his line-up tonight.

Mr. Speaker, I rise today to speak about an issue that is very important to me, the health care of rural veterans and the challenges that these patriotic Americans who have so proudly served our Nation in times of war today face. I am proud to address their concerns about access to health care and the unique obstacles they face for medical treatment.

Why is this so important? The answer is very simple. We owe these brave men and women who fought for our freedom and defended our liberty, including those who are doing so tonight as I speak. Today's soldiers are tomorrow's veterans, and we have those in Iraq and Afghanistan doing once again their duty in order that we might remain this free and proud Nation.

Mr. Speaker, I come from a very rural district. To say that my district is rural is an understatement. The 17th District of Texas is 33,836 square miles, in fact larger, than six States.

This talk about the size of my district can also give my colleagues an idea of how far it is to drive for a veteran to receive health care, in fact how far it is to get anywhere. In the 17th District, there is no subway to take a person from one end to another. A taxi ride would take a few hours and be outrageously expensive, and bus lines do not run from the bedroom community of Ft. Worth to the outskirts of Lubbock.

So what does all of this size and magnitude have to do with rural veterans? Well, it has a lot to do with them. If anyone here has been to my district, they know how long it takes to get from point A to point B, but to veterans in need of health care in West Texas, a 2-hour drive is not just a jaunt down the road or a time to think and reflect. For these folks, a long drive is a very big challenge.

I am proud to stand by the veterans of my district, and again I say, stand as a cosponsor of the Rural Veterans Access to Care Act of 2003.

The gentleman from Nebraska's (Mr. OSBORNE) bill goes a long way to helping to alleviate some of the difficulties faced by rural veterans. I am glad he is stepping onto the field to fight for rural veterans, and I am proud to be standing with him.

I endorse his idea that no less than 5 percent of appropriations to VA health care should be used to improve access to medical services for highly rural or geographically remote veterans.

Last year, I was deeply disappointed by the leadership's implicit acceptance of using veterans' resources for political expediency. The VA appropriations bill for fiscal year 2004 broke a promise made to our veterans. The measure contained $1.8 billion less in veterans' health care than was promised last year by the Republican leadership in the budget resolution. We all know that the leadership's first priority during the budget negotiations last year was achieving large tax cuts.

Along with several of my colleagues, we warned that the commitments made for increasing funding for veterans' health care, along with large tax cuts, could not be kept. For this reason, I supported a smaller tax cut that would allow the promise to be honored. We were later informed that the commitment would be honored, but when it came time to act, the leadership found they could not keep this promise, along with the large tax cut after all, but that was last year.

I am hopeful that 2004 will bring greater sense to those in power. I pray that 2004 will bring greater loyalty to those who were told that they will be remembered.

I think it is important to remember that today's fighting men and women are tomorrow's veterans.

A recent issue that highlights the challenges facing rural veterans is the CARES Commission's recommendation recently that the West Texas VA health system, the VA hospital in Big Spring, Texas, should be closed.

I represented Big Spring up until the redistricting in 2001 removed it from my district, but now my interest in this issue is just as strong today as it was when I represented Big Spring. Most of the population that uses the Big Spring VA center is to the east, specifically in the population areas around Abilene and San Angelo where two Air Force bases fuel the veteran and retiree residents.

Given this fact, it only takes plain common sense to see that the Big Spring VA is well-positioned to keep the promise made to our veterans and military retirees for health care.

I have had some folks ask me why we are in such the forefront of this challenge. My answer to them was threefold: So many of the veterans in my district are treated in the Big Spring VA hospital; all the veterans and military retirees of this country deserve the best health care and benefits we can give them; and that we are in very much dedicated to seeing that just that happens.

I was pleased to participate in a meeting with VA Secretary Anthony Principi that was called by Senator KAY BAILEY HUTCHISON. The meeting was very productive and allowed me to assert my belief that the Big Spring VA needs to be both kept opened and strengthened for rural veterans of West Texas.

I understand the need for our government agencies to periodically review missions, goals and facilities, but such reviews need to be deeper than number crunching.

Mr. Speaker, I am proud to stand in support of the bill. I believe it goes a long way to getting more people to recognize the importance of health care for rural veterans, as well as all veterans.

INTRODUCTION OF RURAL VETERANS ACCESS TO CARE ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Nebraska (Mr. OSBORNE) is recognized for 5 minutes.

Mr. OSBORNE. Mr. Speaker, I would like to thank the gentleman from Texas for his kind words and his support. The gentleman from Texas (Mr. STENHOLM) and I share very similar Districts, very large districts.

My district has 68 counties, 160,000 square miles. It is the third or fourth largest district in the United States. As a result, veterans who need health care must often travel several hours, sometimes hundreds of miles, to access VA health care. Sometimes this is as much as a 3-day trip, a day down, a day at the facility and a day back, and the problem is that usually transportation is very difficult to access. A person has to have a son or a daughter or a friend or somebody who can take off work for 2 days or 3 days to provide that transportation. So it is a tremendous hardship on a number of people.

Often, all a veteran needs is to adjust medication, have a blood pressure test, receive an EKG or take a blood analysis. So these are very simple, routine matters that still take tremendous resources to have attended to. Routine medical care could be handled at the local hospital or clinic where that person resides or near where that individual resides, and this would require minimal travel time, minimal waiting time for an appointment because sometimes these appointments, you have a waiting time of 3, 4, 5, 6 months and also minimal expense.

So I looked at various options to address this problem and developed H.R. 2379, the Rural Veterans Access to Care Act. H.R. 2379 would encourage the VA to use its authority to contract for routine medical care with local providers for geographically remote veterans who are enrolled in the VA. They must be enrolled in the VA previously in order to access the provisions of this bill.

So how will it be funded? The VISN director will use the funding for acute or chronic symptom management, nontherapeutic medical services and other medical services as determined appropriate by the director of the VISN after consultation with the VA physician responsible for primary care for the veteran.

H.R. 2379 sets aside 5 percent of the appropriated VA medical care allocation in each VISN to be used for routine medical care for geographically remote veterans. We are talking about taking just 5 percent of the funding and setting it aside for veterans who live at some significant distance from a VA facility.

H.R. 2379 uses 60 minutes travel time or more as an initial determinant, but there is also an exception to the legislation if the VA finds it is a hardship for a veteran to travel to a VA facility, regardless of how long it will take. It is conceivable that somebody might live only 30 or 40 minutes away but because of age or severity of illness or whatever it may be much more convenient to attend a closer facility that would enhance that person's health.

I want to assure veterans, this legislation is not a voucher program. My legislation allows only enrolled veterans who have been approved by the VA to seek routine care from a local provider.

Reducing demands for routine care could also help with appointment backlogs in VA facilities, which are significant at this time.

According to the CARES Commission report, the benefits of contracting are, it can add capacity and improve access faster than can be accomplished through capital investment. In other words, building new facilities is not nearly as efficient as letting them use preexisting local clinics or hospitals. It provides flexibility to add and discontinue services as needed and allows VA to provide services in areas where the small workload may not support a VA infrastructure, which is very much the case in my district and in the gentleman from Texas' (Mr. STENHOLM), and this was for highly rural veterans.

During the hearings, the CARES Commission received testimony stating that contracted care improves access and that there was little dissatisfaction with contracted care. Therefore, I urge my colleagues to support H.R. 2379 and help our rural veterans as they access VA health care.

The SPEAKER pro tempore (Mr. BURGESS). Under a previous order of the House, the gentleman from Colorado (Mr. MCINNIS) is recognized for 5 minutes.

(Mr. MCINNIS addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

IN SUPPORT OF RURAL VETERANS ACCESS TO HEALTH CARE ACT OF 2003

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Hawaii (Mr. CASE) is recognized for 5 minutes.

Mr. CASE. Mr. Speaker, good evening and aloha.

I am very happy to stand on the floor of the House today and join my colleagues the gentleman from Nebraska (Mr. OSBORNE), the gentleman from Texas (Mr. STENHOLM) and many others in introducing the Rural Veterans Access to Health Care Act of 2003.

We are all very well aware of the commitment that we have made, at least in principle, although the practice has been lacking of recent years, but the principle that we will take care of veterans when they come home. The truth, however, is that as we try to honor that principle and the practice, the equality of access to health care throughout our country is inconsistent, and this is most particularly true in the rural areas of our country. In these areas, our veterans simply do not have the same level of access to the veterans' health care as they do in the urban areas.

This is true in Hawaii's 2nd District, which is a rural area of our country, just as others are, but we have a little wrinkle in the 2nd Congressional District that creates a unique complication. The wrinkle is that my district is not contiguous. It is made up of islands. It is not possible for the veterans of my district to hop on the nearest road and get to the nearest clinic. It is not possible for the most part for my veterans to hop on the nearest ferry to get to the nearest clinic. Their access is by air.